

**Testimony of**

**Nancy Bonalumi, RN, MS, CEN  
2006 President  
Emergency Nurses Association**

**to the**

**Subcommittee on Bioterrorism and Public Health Preparedness  
Committee on Health, Education, Labor and Pensions  
United States Senate**

**on**

**Crisis in the ER: How Can We Improve Emergency Medical Care**

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Good afternoon, Mr. Chairman and members of the Subcommittee. Thank you for convening this roundtable to examine the current condition of emergency care in our nation. Characterized as “overburdened, short of resources, under funded, and fragmented,” the present situation is an environment where emergency departments are less able to serve as the country's safety net in ordinary situations, much less able to appropriately handle the extraordinary events of natural and man-made disasters.

I am Nancy Bonalumi, Director of Emergency and Trauma Nursing at the Children's Hospital of Philadelphia, and the 2006 President of the Emergency Nurses Association (ENA). ENA is the only professional nursing organization dedicated to defining the future of emergency nursing and emergency care through expertise, innovation, and leadership. It serves as the voice of nearly 32,000 members and their patients through research, publications, professional development, injury prevention, and patient education. Recognized as an authority in the discipline of emergency care and its practice, ENA was invited by the IOM to share its data and expertise on the current state of U.S. emergency departments (EDs). On behalf of the Emergency Nurses Association, I appreciate this opportunity to engage with the Subcommittee and explore options that Congress might implement to improve emergency care by reducing crowding in the nation's emergency departments. Let me state right up front, **ENA does not support holding or boarding in the ED because this practice is not in the best interest of patients.**

Crowding is a systems issue, and not confined to the ED. Its causes often originate outside of the immediate control of the ED. Some of these are: an inadequate number of beds in the hospital with the right equipment to care for the sickest patients, an insufficient number of nurses who can provide the proper monitoring, and elective surgery patients occupying beds needed by emergency patients. On any given day, each of these factors affects access to emergency care, and threatens patient safety and patient outcomes. Meaningful change for this system demands examination and problem-solving at the institutional level, as well as at local, regional, and national levels.

## **FRAGMENTATION/REGIONALIZATION**

**ENA supports government efforts to create a non-federal advisory council to provide input to FICEMS.** Measures to promote systems thinking and coordination include forming a national-level forum to facilitate effective communication and coordination related to emergency care between and among federal stakeholders. To this end, ENA supported the recent authorization of the Federal Interagency Committee on Emergency Medical Services (FICEMS) to address the regional, state, and local EMS systems needs. To enhance effective two-way communications between FICEMS and the outside world, a non-federal advisory council is needed to provide input to FICEMS from stakeholders with daily operational experience in EMS.

**ENA supports the IOM's assertion that the U.S. emergency care system needs to be coordinated and regionalized.** The IOM report acknowledges that the nation's emergency care system is saturated, highly fragmented, and variable in the delivery of care. In its 2002 *Mass Casualty Incidents* position statement, ENA recommended that emergency services be seamless with 911 and dispatch, ambulances, emergency medical services (EMS) personnel, hospital EDs, and trauma centers and specialists working in a coordinated manner. The ENA believes emergency care also must be regionalized to help ensure the patient is transported to the right hospital at the right time for the right care.

**ENA supports the immediate reinstatement of funding for the HRSA Trauma-EMS Program in order to renew the work in the states toward establishment of state-wide trauma systems.** The Trauma-EMS Program, administered by the Health Resources and Services Administration (HRSA), provided states with grants for planning, developing, and implementing state-wide trauma care systems. Although only eight states have fully developed trauma systems, these state-wide health care systems could be used as

models for full regionalization of care. ENA recognizes the necessity of the Trauma-EMS Program, which has been the only federal source available to build a trauma system infrastructure in the United States. When it existed, the Trauma-EMS Program, which lost its funding in FY 2006, provided critical national leadership, and leveraged additional scarce state dollars, to optimize trauma care through system integration that offered seriously injured individuals, wherever they lived, prompt emergency transport to the nearest appropriate trauma center within the "golden hour." The IOM report bolsters support for such regionalized models of care by drawing on substantial evidence that "demonstrates that doing so [i.e., creating a coordinated, regionalized system] improves outcomes and reduces costs across a range of high-risk conditions and procedures."

**ENA supports the IOM's call for a series of research demonstration projects that will put these ideas into practice by testing these strategies under various emergency care conditions.**

Achieving an integrated, regionalized emergency care system takes coordination, commitment of staff, development and implementation of standards of care, a process for designating trauma centers, and evaluation. To this end, ENA has advocated a regionalization that gathers together all community stakeholders to examine all alternatives for providing appropriate patient care and better patient outcomes. Our organization supports a best practice of coordinated, community-wide response planning, using a common framework that is applicable to all hazards and that links local, state, regional, and national resources.

## **CROWDING**

Crowding in our nation's emergency departments is of increasing concern. In our 2005 position statement ***Crowding in the Emergency Department***, ED crowding is described as "a situation in which the identified need for emergency services outstrips available resources in the emergency department. This situation occurs in hospital emergency departments when there are more patients than staffed ED treatment beds and wait times exceed a reasonable period."

When crowding occurs, patients are often placed in hallways and other nontreatment areas to be monitored until ED treatment beds or staffed hospital inpatient beds become available. In addition, crowding may contribute to an inability to triage and treat patients in a timely manner, as well as increased rates of patients leaving the ED without being seen. As a result of crowding, hospitals often implement ambulance diversion measures.

An emergency care system that is beyond saturation on a daily basis will have limited ability to respond to the surge of patients related to catastrophic events. The federal government must establish clear leadership and directed funding support to coordinate the functions of emergency care, as well as assist in providing system incentives for nonemergency care that is delivered in areas outside of the ED.

One aspect of crowding that ENA continues to address concerns the interpretation of emergency care's federally mandated regulations. ENA wholeheartedly endorses unencumbered access to quality emergency care by all individuals regardless of their financial status. However, EMTALA, the ***Emergency Medical Treatment and Labor Act*** which ensures public access to emergency services regardless of ability to pay, has had the unintentional effect of increasing unnecessary visits to the ED for acute and chronic conditions that do not meet the Centers for Medicare and Medicaid Services' (CMS) definition of "emergency medical condition."

ENA acknowledges an attempt by CMS to lessen the restrictions regarding patients with nonemergent conditions. Despite a CMS clarification, much confusion continues to surround this issue, grounded in fear of possible reprisals for failure to strictly adhere to EMTALA mandates. EMTALA continues to limit an ED's options to

manage its patient load by limiting its ability to send nonurgent patients off-site for clinical care, rather than conducting a full medical assessment in the ED. Nurses cannot tell a patient probable wait times or suggest alternatives for care under the current rules. With severe crowding and ambulance diversions identified as a national crisis, compounded by the increase in patients using the ED for primary care, some flexibility is needed for clinical judgment by an ED practitioner (who has experienced an actual encounter with the patient) to identify those patients who do not obviously meet the definition of an emergency medical condition.

Notwithstanding EMTALA regulations, the problem of crowding is not confined to the ED, and is considered a systems issue, which can be examined at department and institution levels as well as at local, regional, and national levels. The factors contributing to ED crowding are numerous and varied and have been well documented in the literature. The root causes of ED crowding are embedded in the crisis of health care in the U.S., requiring solutions that may fall outside of the ED's control. The ENA believes crowding is caused by

- Hospital/trauma center closures;
- Lack of inpatient beds, forcing emergency departments to hold patients;
- Increased use of emergency departments over the past decade; and
- Lack of universal access to primary and preventative health care and the use of the emergency department for primary care.

#### **To address crowding, ENA recommends increased federal funding to support:**

- Collaborative research by emergency nurses and physicians to develop and implement new flow management solutions for the emergency department to both prevent and manage ED crowding;
- Professional and public awareness programs as well as legislative efforts to reduce visits to the ED by (1) strengthening capacity for nonemergent care by increasing access to primary care providers in the community and teaching when and how to access emergency care; (2) reducing the numbers of uninsured and underinsured; (3) reducing trauma caused by preventable injuries, violence, and substance abuse; and (4) improving prevention, wellness, and disease management efforts; and
- Evaluation and prioritized performance incentives that increase capacity and efficiency, not only in the emergency department, but within hospitals and other patient care facilities in order to help reduce the burdens suffered by ED patients when emergency departments become too crowded for patients needing specialized care.

#### **NURSING WORKFORCE AND NURSING FACULTY SHORTAGES**

The IOM report also notes that nursing shortages in U.S. hospitals continue to disrupt hospital operations and are detrimental to patient care and safety. Because of the unique insight and clinical knowledge of an experienced emergency nurse, the nursing shortfalls constitute a loss of expertise in the system. Nurses are not interchangeable resources. The expertise of a seasoned ED nurse is critical to achieve quality patient outcomes in a dynamic health care system that demands competencies for a multitude of situations. Hospital staffing systems must acknowledge the need for, and incorporate, training and education time and funding for emergency nurses.

During the 10-year span of 2002 to 2012, health care facilities will need to fill more than 1.1 million RN job openings. The nursing community has been urgently asking Congress to increase funding for HRSA's Nursing Workforce Development Programs, especially to increase funding for nursing faculty preparation. Do you know that federal investment in nursing education is less than six hundred-thousandths of the total federal budget? Or that in 1974, during the last serious nursing shortage, Congress appropriated \$153 million for nurse education programs. In today's dollars that would be worth \$592 million, approximately four times what the federal government is spending now.

**ENA agrees with the IOM's recommendation that federal agencies must jointly undertake a detailed assessment of emergency and trauma workforce capacity, trends, and future needs to develop strategies meeting these needs in the future.** Applications to nursing programs have increased but at the same time an estimated 147,000 qualified applications were turned away from nursing programs at all levels for the academic year 2004-2005 in large part because of the severe faculty shortage. The results of the disparities in workforce supply and demand are played out in staff shortages in the majority of emergency departments across the country – from staff who are struggling to provide care, to ED crowding, to ambulance diversions, and to the patients who ultimately suffer. The situation is only going to get worse as the population ages.

**ENA supports the IOM's assertion that national standards for core competencies applicable to nurses and other key emergency and trauma professionals be developed using a national, evidence-based, multidisciplinary process.** To date, the ENA-affiliated Board of Certification of Emergency Nursing (BCEN®) has credentialed 14,000 Certified Emergency Nurses (CEN®) and more than 1,000 Flight Registered Nurses (CFRN®). BCEN® also recently announced the launch of the Certified Transport Registered Nurse (CTRN™) certification for nurses qualified to move patients between medical facilities.

**The ENA is on record advocating increased federal efforts to support:**

- Effective strategies for the recruitment, retention, and continuing education of registered nurses working in emergency departments, providing safe, efficient, quality care, especially during crisis situations when the ED is crowded and functioning above capacity; and
- New strategies to increase the numbers of individuals pursuing nursing careers, as well as initiatives to increase qualified nursing faculty, who are vital to addressing the nursing shortage.

**STATUTORY NATURE OF U.S. EMERGENCY CARE**

When the American public is asked about its views on trauma centers and trauma systems, large majorities value them as highly as having a police or fire department in their community. In addressing the crucial nature of regionalized trauma services, the IOM report notes that trauma care "is widely viewed as an essential public service." The report further states that "unlike other such services [e.g., electricity, highways, airports, and telephone service . . . created and then actively maintained through major national infrastructure investments] access to timely and high quality . . . trauma care has largely been relegated to local and state initiative."

The dilemma of emergency care runs deeper than the disparity between the perceptions of emergency care as a public service and the funding underlying the system. A distinctive policy characteristic of emergency care is

that emergency care is legislated (e.g., as previously suggested in the EMTALA regulations discussion). Of all the health care disciplines, emergency care is the one that is mandated by the United States government. In effect, the government has promised the people that emergency care will be a service to which the public has a lawful right (not just a discretionary, moral right). This statutory nature holds special implications, evoking general questions such as:

- How does federal support of this public service compare to support of other legislated services?; and
- To what degree is the government legally accountable for delivery of this right/public service?

For emergency care nurses, this legal requirement reinforces respective professional duties and ethical commitments. As front-line providers of emergency care, ENA believes it is essential that every person in our country has access to a system that provides definitive care as quickly as possible. We ask that you support the recommendations that ENA has outlined in its written testimony and work with us to create a coordinated, regionalized, and accountable emergency care system that is staffed, trained, and prepared for our communities when they need us. We cannot achieve it alone.

Thank you.